



## Missouri Pharmacy Program – Preferred Drug List



### ***Inhaled Corticosteroids***

***Effective 12/01/2004***

***Revised 07/03/2008***

#### **Preferred Agents**

- QVAR
- Azmacort®
- Aerobid/Aerobid-M®
- Flovent HFA®
- Flovent Diskus/Rotadisk®
- Advair Diskus®
- Advair HFA®
- Asmanex®

#### **Non-Preferred Agents**

- Pulmicort® Flexhaler
- Symbicort

<b><u>Approval Criteria</u></b>	<b><u>Denial Criteria</u></b>
Failure to achieve desired therapeutic outcomes with documented trial period for 3 or more preferred agents.	Lack of adequate trial on required preferred agents.
Documented ADE/ADR to preferred agents.	Therapy will be denied if no approval criteria are met.
Documented compliance on current therapy regimen.	
Trial and Failure on Advair allows access to Symbicort (combination product to combination product)	Drug Prior Authorization Hotline: (800) 392-8030